

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN3309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/14/2011
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF RED BANK			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 RUNYAN DR CHATTANOOGA, TN 37405		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies  During the annual licensure survey conducted on September 12-14, 2011, at Life Care Center of Red Bank, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 002			

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6090

4Z8M11

If continuation sheet 1 of 1

OCT 03 2011